

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05016

05013

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL Leonardtown c. LENGTH OF STAY IN 1b 16 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Mary's Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Rural Hollywood d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jane Middle Loretta Last Abell		4. DATE OF DEATH Month April Day 3 Year 19 62	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 27, 1879	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Wible		14. MOTHER'S MAIDEN NAME Catherine Hayden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT W. Manning Abell		Address Hollywood, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary arterio sclerosis DUE TO (b) Generalized arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 years 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1962 to April 3, 1962 that (I) (we) last saw the deceased alive on April 2, 1962 and that death occurred at 12 M. from the causes and on the date stated above.			
22a. SIGNATURE P. J. Bean		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) P. J. Bean M.D.		22d. ADDRESS Great Mills, Md.	
23a. BURIAL, CREMATION, Burial		23b. DATE THEREOF 4/6/62	
23c. NAME OF CEMETERY OR CREMATORY St. John's		23d. LOCATION (City, town or county) (State) Hollywood, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		25a. REC'D BY REGISTRAR APR 9 '62	
ADDRESS Leonardtown, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

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05017

CERTIFICATE OF DEATH

Reg. Dist. No. 05014

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown,				c. LENGTH OF STAY IN 1b 10 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Valley Lee X			
				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anita Middle C. Last Biscoe				4. DATE OF DEATH Month April Day 12, Year 1962			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 29, 1961		9. AGE (In years last birthday) yrs. 9 Mo. 14 Days 14 Hours Min.	IF UNDER 1 YEAR Months 9 Days 14 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME XXXXXXXXXXXX				14. MOTHER'S MAIDEN NAME Geniveve Biscoe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Mother same as # 2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-9-62 X Branchpneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1-2 days DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1-2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 April 1962 , to 19 , that I last saw the deceased alive on 12 April 1962 , and that death occurred at P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lexington Park, Maryland DATE SIGNED 14 April 62							
ACTUAL SIGNATURE Ernest D. Rehm M.D.				PHYSICIAN'S NAME (Type) Ernest Rehm M. D. Lexington Park, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/14/62		22c. NAME OF CEMETERY OR CREMATORY St. Mark's		22d. LOCATION (City, town, or county) (State) Valley Lee, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE APR 24 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-025378

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5022 • J. Neurosci., July 26, 2006 • 26(30):5017–5027

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FOR STATE
HEALTH DEPT.

05018

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05015

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baden Rural d. STREET ADDRESS 16X2	
3. NAME OF DECEASED (Type or print) William Edward Boswell		4. DATE OF DEATH Month April Day 14 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY HOME CONSTRUCTION	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William F. Boswell		14. MOTHER'S MAIDEN NAME Bessie Burch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 1936	
17. INFORMANT Jessie M. Boswell		Address BRANDYWINE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poisoning 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased attached hose to exhaust from car window	
20c. TIME OF INJURY Month, Day, Year Hour a.m. April 14, 1962 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William D Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WILLIAM D BOYD		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-2-62	
22c. NAME OF CEMETERY OR CREMATORY TRINITY MEMORIAL		22d. LOCATION (City, town, or country) (State) WALDORF, MARYLAND	
23. FUNERAL DIRECTOR The HUNTT Funeral Home, WALDORF, MD.		ADDRESS	
24a. REC'D BY REGISTRAR MAY 3 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

05016

05019

Reg. Dist. No.

1. PLACE OF DEATH COUNTY St. Mary's MARYLAND CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Leonardtown, HOSPITAL OR INSTITUTION OR STREET ADDRESS St. Mary's Hospital				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY St. Mary's CITY (If outside corporate limits, write RURAL and give nearest town) Chaptico STREET ADDRESS (if rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Henry Fowler Burroughs				4. DATE OF DEATH (Month) (Day) (Year) April 1, 1962			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Separated	8. DATE OF BIRTH March 7, 1889	9. AGE last birthday 73 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY McDowell Pyle Co,		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aqualli A. Burroughs				14. MOTHER'S MAIDEN NAME Mary Frances Fowler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS Hospital Records			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH 5d
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebral Thrombosis							
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 19, 1955 to April 1, 1962 , that I last saw the deceased alive on 3/31, 1962 , and that death occurred at 11 A.M. from the causes and on the date stated above.							
SIGNATURE Sam L. Burke		M.D.		ADDRESS (Street, city, town, state) Mechanicsville, Maryland		DATE SIGNED 4/1/62	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/4/62		NAME OF CEMETERY OR CREMATORY St. Joseph		LOCATION (City, town, or county) (State) Morganza, Md.	
24. REC'D BY REGISTRAR DATE APR 4 '62		REGISTRAR'S SIGNATURE Charles S. Kenna		25. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley ADDRESS Leonardtown, Md			

APR 4 '62

CERTIFICATE OF DEATH

1918

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A111 (4)
15M 9/59

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05020

Items 6 & 9 Filed 5/3/62 ink

05017

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE District of Columbia COUNTY District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital		d. STREET ADDRESS 1140-44th Pl.	
3. NAME OF DECEASED (Type or print) First Milton Middle A. Last Clark		4. DATE OF DEATH Month April Day 22 Year 19 62	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/23/1896 1897 65/66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Steamfitter D.C. Govt		11. BIRTHPLACE (State or foreign country) WASH, D.C.	
13. FATHER'S NAME William Clark		14. MOTHER'S MAIDEN NAME Elizabeth White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WW # 8-12-42-7-20-45		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MOLLIE H CLARK		Address 1140-44th Pl WASH DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 21, 1962 to April 22, 1962 that (I) (we) last saw the deceased alive on April 22, 1962 and that death occurred at 1:05 PM from the causes and on the date stated above.			
22a. SIGNATURE S. Laurel		22b. DATE SIGNED 3/22/62	
22c. PHYSICIAN'S NAME (Type) S. Laurel MD		22d. ADDRESS Leonardtwn, Md.	
23a. BURIAL, CREMATION, OR DISPOSAL (Specify) BURIAL		23b. DATE THEREOF 4-26-62	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL		23d. LOCATION (City, town, or county) (State) FT MYER Va	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		25a. REC'D BY REGISTRAR 517-11th St SE WASH DC	
25b. REGISTRAR'S SIGNATURE 517-11th St SE WASH DC		25c. DATE APR 24 1962	

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FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, marking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the funeral director's permit. File pages 1 and 2 with the State Board of Health. File page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. In any event, within 72 hours after death, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
SM 7/59

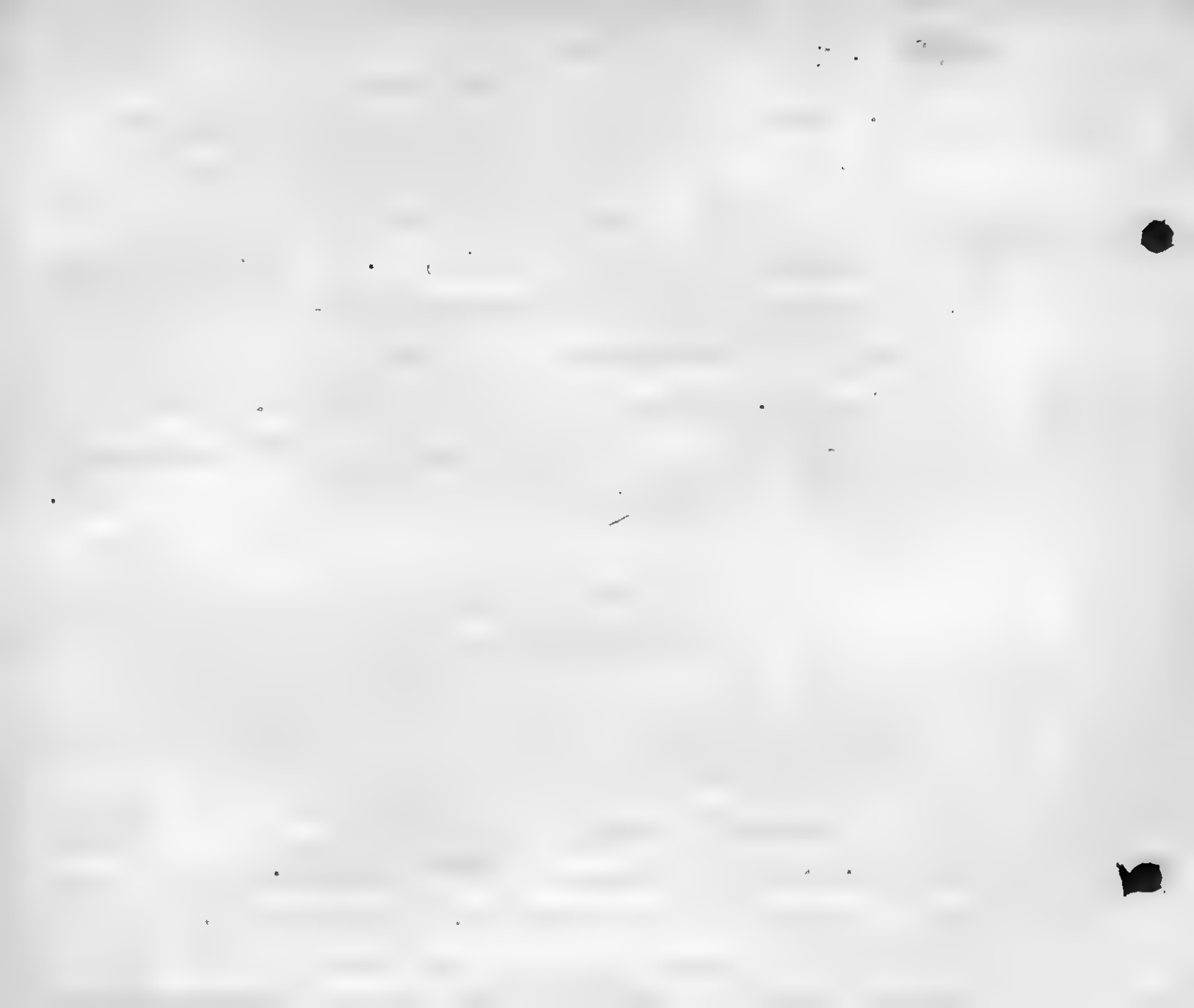
05021

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05018

1. PLACE OF DEATH a. COUNTY St. Marys b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clements c. LENGTH OF STAY IN b. MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rural		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clements d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) William Russell Cullins, Sr.		4. DATE OF DEATH April 19 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 18, 1890-72^{rs}
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William E. Cullins		14. MOTHER'S MAIDEN NAME Mary E. Russell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Wm. Russell Cullins, Jr. Clements, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO (b) Immed. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) ---	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. ---		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Wm D Boyd		DATE SIGNED 4/19/62	
EXAMINER'S NAME (Type) Wm. D. Boyd, MD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/23/62	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cem.		22d. LOCATION (City, town, or country) (State) Bushwood, Md.	
23. FUNERAL DIRECTOR P.B. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR --- 24b. REGISTRAR'S SIGNATURE Arthur S. H...	

MEDICAL CERTIFICATION



05022

CERTIFICATE OF DEATH

Reg. Dist. No. 05019

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 11 hrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Hollywood		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Adele Last Davis		4. DATE OF DEATH Month April Day 15 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1886
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR: Months 7 Days 15 Hours 15 Min 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Thomas Raley		14. MOTHER'S MAIDEN NAME Elizabeth Ann Dorsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (- yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT William D. Davis Address Hollywood, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 12 hours	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1946 to April 15, 1962 that I last saw the deceased alive on April 15, 1962 , and that death occurred at 7:20 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Lexington Park, Maryland DATE SIGNED 4-15-62			
ACTUAL SIGNATURE W. H. Patrick M.D.		M.D. 323 Medical Drive Lexington Park, Md. 4-15-62	
PHYSICIAN'S NAME (Type) W. H. Patrick M.D.		Lexington Park, Maryland	
22a. BURIAL, CREMATION, REINTERMENT Burial	22b. DATE THEREOF April 18, 1962	22c. NAME OF CEMETERY OR CREMATORY Joy Chapel	22d. LOCATION (City, town, or county) (State) Hollywood, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE APR 17 '62	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

05023

CERTIFICATE OF DEATH

05020

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Park Hall		c. LENGTH OF STAY IN 1b 6 mo	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Park Hall		d. STREET ADDRESS Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katherine Middle Mae Last Day		4. DATE OF DEATH Month April Day 5 Year 19 62	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH may 27, 1886
9. AGE (in years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 2 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10b. KIND OF BUSINESS OR INDUSTRY Clothing	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles H. Stephenson		14. MOTHER'S MAIDEN NAME Katherine Kie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 113 14 1701	
17. INFORMANT Address Rt 1 Box 360 Lexington Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Failure 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio-sclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1962 to April 5, 1962 that (I) last saw the deceased alive on April 5, 1962 , and that death occurred at 11:35 A.M. from the causes and on the date stated above			
22a. SIGNATURE Julian S. LANE		22b. DATE SIGNED 4/5/62	
22c. PHYSICIAN'S NAME (Type) Julian S. LANE		22d. ADDRESS Lexington Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/9/62	
23c. NAME OF CEMETERY OR CREMATORY Nassau Cemetery		23d. LOCATION (City, town or county) (State) Nassau, New York	
24. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		25a. REC'D BY REGISTRAR DATE APR 10 '62	
25b. REGISTRAR'S SIGNATURE Carroll P. Hume			

1
FOR STATE
HEALTH DEPT. (M)
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05024 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05021

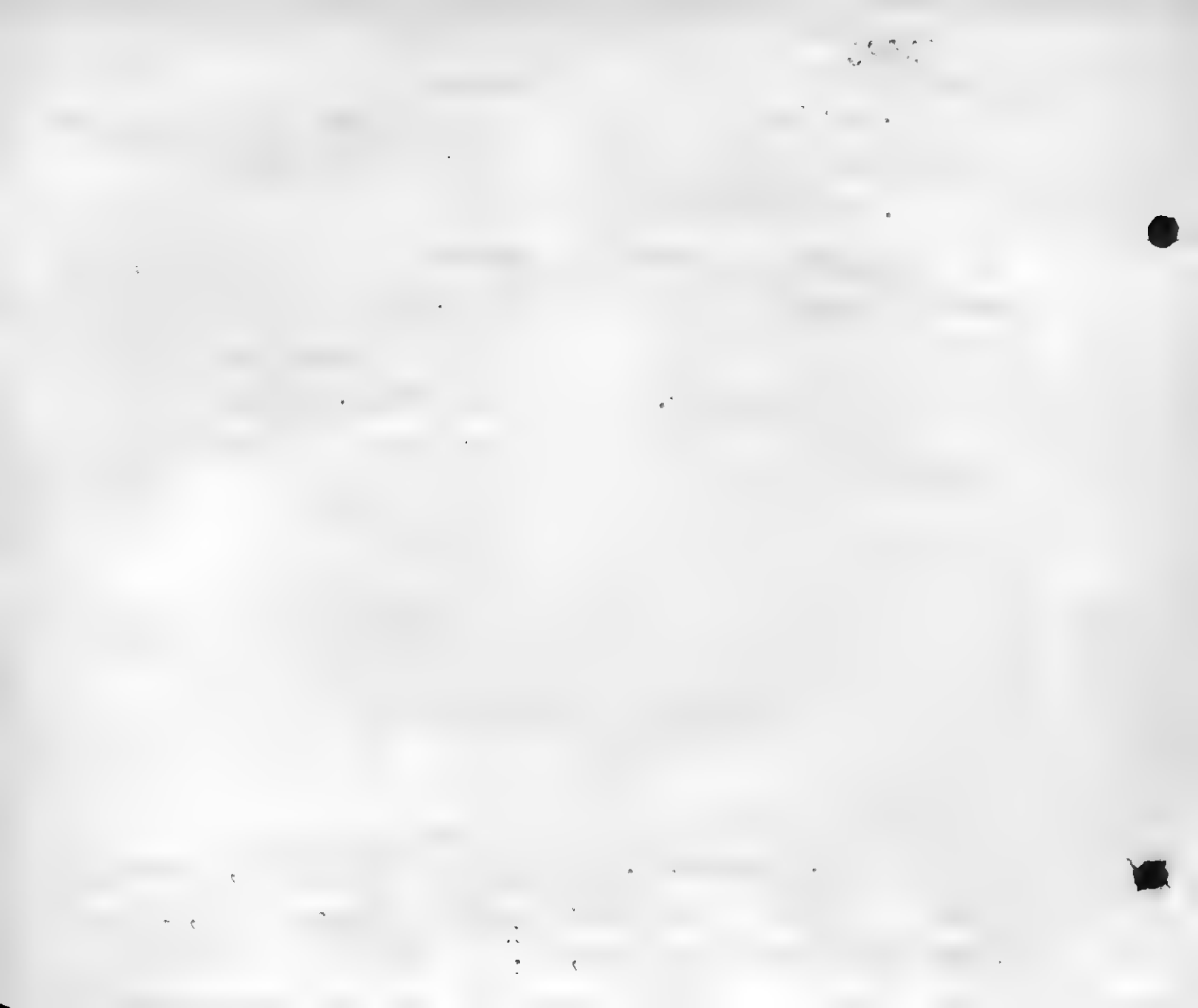
1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) Rural Lexington Park		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Lexington Park	
c. LENGTH OF STAY IN life Life		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Cornelius Daye		4. DATE OF DEATH April 17, 1962	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1936	
9. AGE (In years last birthday) 25 yrs.		10. AGE (In years UNDER 1 YEAR) Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. KIND OF BUSINESS OR INDUSTRY Gas station	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Samuel Daye		16. MOTHER'S MAIDEN NAME Florence Chase	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		18. SOCIAL SECURITY NO.	
19. INFORMANT Father		Address Same as # 2 above	
18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Basilar Skull Fracture DUE TO Conditions, if any, which gave rise to immediate cause (b) 812X (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		INTERVAL BETWEEN ONSET AND DEATH Immediate	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian hit by auto	
20c. TIME OF INJURY Hour 6:40 P.M. Month, Day, Year April 17, 62		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 235		20f. (City or town) (County) (State) Harmonville St Mary Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE W.D. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William D. Boyd M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) W. Clarke Mattingley Leonardtown, Md.		DATE SIGNED 4/19/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/20/62	
22c. NAME OF CEMETERY OR CREMATORY Holiness Cemetery		22d. LOCATION (City, town, or country) (State) Park Hall, Maryland	
23. FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE APR 24 '62	
24b. REGISTRAR'S SIGNATURE Wm. S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05025
05022

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtwn c. LENGTH OF STAY IN 16 DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Mary's Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Leonardtown d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Mary Middle Catherine Last Goddard		4. DATE OF DEATH Month April Day 23 Year 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 16, 1960	
9. AGE (In years last birthday) 1 yrs. 9 Months 7 Days 1 Hours 1 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence A. Goddard Jr.		14. MOTHER'S MAIDEN NAME Alberta T. Goddard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 1	
17. INFORMANT Mother same as # 2 above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Distress DUE TO (b) Heart Failure DUE TO (c) Epileptic Seizure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e):		INTERVAL BETWEEN ONSET AND DEATH 12 hr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/13/62 to 4/23/62 , that (I) last saw the deceased alive on 4/23/62 , and that death occurred at 5:00 M, from the causes and on the date stated above.			
22a. SIGNATURE J. P. Jarboe		22b. DATE SIGNED 4/23/62	
22c. PHYSICIAN'S NAME (Type) J. P. Jarboe M. D.		22d. ADDRESS Great Mills, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/25/62	
23c. NAME OF CEMETERY OR CREMATORY Our Lady's Chapel		23d. LOCATION (City, town or county) (State) Medley's Neck, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		25a. REC'D BY REGISTRAR APR 30 '62	
ADDRESS Leonardtwn, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Thoms	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05026

05023

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Rural Park Hall c. LENGTH OF STAY IN b. MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rural Park Hall		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Rural Park Hall d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice Smith Lloyd		4. DATE OF DEATH April 28, 1962	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Oct. 28, 1884 9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife 11. BIRTHPLACE (County & State or foreign country) Scotland, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Frank Smith		14. MOTHER'S MAIDEN NAME Alice Dunbar	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. Mrs F.D. Bohanan 17. INFORMANT Park Hall, Maryland Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Carcinomatosis 1-5-0 DUE TO Adenocarcinoma of Stomach Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Primary Carcinoma of Ovary PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 3-4 weeks Dec. 1959 Dec. 1960			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/28, 1939 , to 4/28, 1962 , that (I) (we) last saw the deceased alive on 4/22, 1962 , and that death occurred at 4:30 P.M. from the causes and on the date stated above			
22a. SIGNATURE Robert T. Fuchs 22c. PHYSICIAN'S NAME (Type) Robert Fuchs M. D.		22b. DATE SIGNED 4/30/62 22d. ADDRESS Leonardtwn, Maryland	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial 23b. DATE THEREOF May 1, 1962		23c. NAME OF CEMETERY OR CREMATORY St. Michael's 23d. LOCATION (City, town or county, (State) Ridge, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley ADDRESS Leonardtwn, Md.		25a. REC'D BY REGISTRAR MAY 3 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Harris	



05027

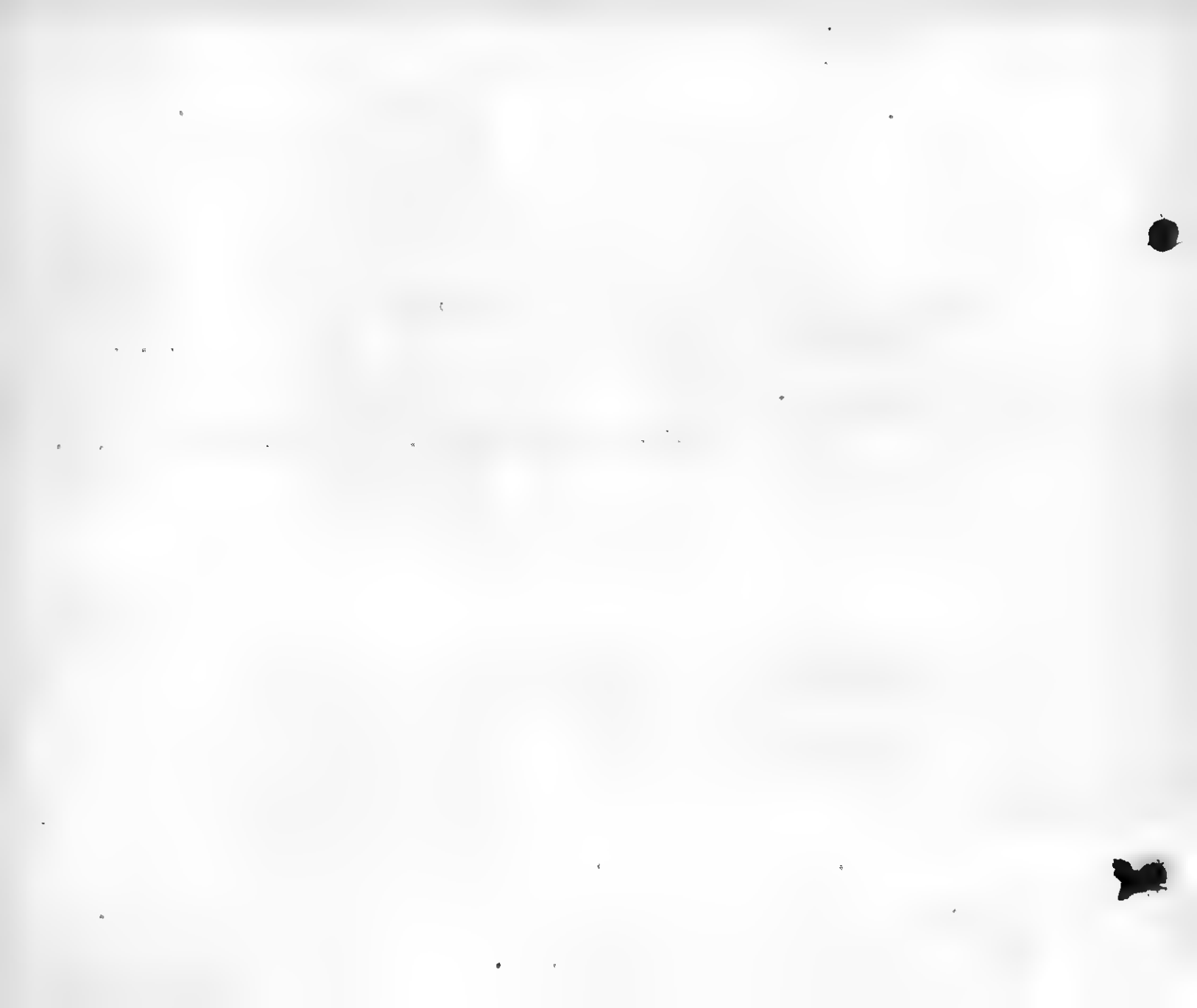
CERTIFICATE OF DEATH

Reg. Dist. No. 05024

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mechanicsville				c. LENGTH OF STAY IN 1b 1 year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Amy Middle Theresa Last Mays				4. DATE OF DEATH Month April Day 18 Year 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1896	
9. AGE (In years last birthday) yrs. 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Turner				14. MOTHER'S MAIDEN NAME Mary Turner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-22-0380		INFORMANT Address Mrs Edna M. Turner Mechanicsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V. disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic hypertension							INTERVAL BETWEEN ONSET AND DEATH 1 hour
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1958 to April 18, 1962 , that I last saw the deceased alive on 4/18/62 , and that death occurred at 2:35 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Mechanicsville, Md. DATE SIGNED 4/19/62							
ACTUAL SIGNATURE J. Roy Guyther M.D.				PHYSICIAN'S NAME (Type) J. Roy Guyther M.D. Mechanicsville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/21/62		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Newport, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE APR 24 1962		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05025

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtown,		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Park Hall	
c. LENGTH OF STAY IN IS 13 days		d. STREET ADDRESS St. Mary's Hospital	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Russell Last Quirk		4. DATE OF DEATH Month April Day 6, Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1881
9. AGE (in years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Quirk		14. MOTHER'S MAIDEN NAME Elizabeth Jane Moody	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 220 32 455A	
17. INFORMANT Mrs Nell Q. Levay		Address St. Mary's City, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Myocardial Infarction Abnormal Insufficiency Septicemia DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Overo: Renal calculus & Pyelitis		INTERVAL BETWEEN ONSET AND DEATH 3 min. days days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Jan 12, 1962 to 4/6/62 that (I) (we) last saw the deceased alive on 4/6/62 and that death occurred at 4:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE J. P. Jarboe M.D.		22b. DATE SIGNED APR 13 '62	
22c. PHYSICIAN'S NAME (Type) J. P. Jarboe M.D.		22d. ADDRESS Great Mills, Maryland	
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE THEREOF 4/9/62	
23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		23d. LOCATION (City, town or county) (State) Great Mills, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		25a. REC'D BY REGISTRAR APR 13 '62	
25b. REGISTRAR'S SIGNATURE Robert S. Thomas			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05029

Item 7 Film 0312-5/1/62 mb

05026

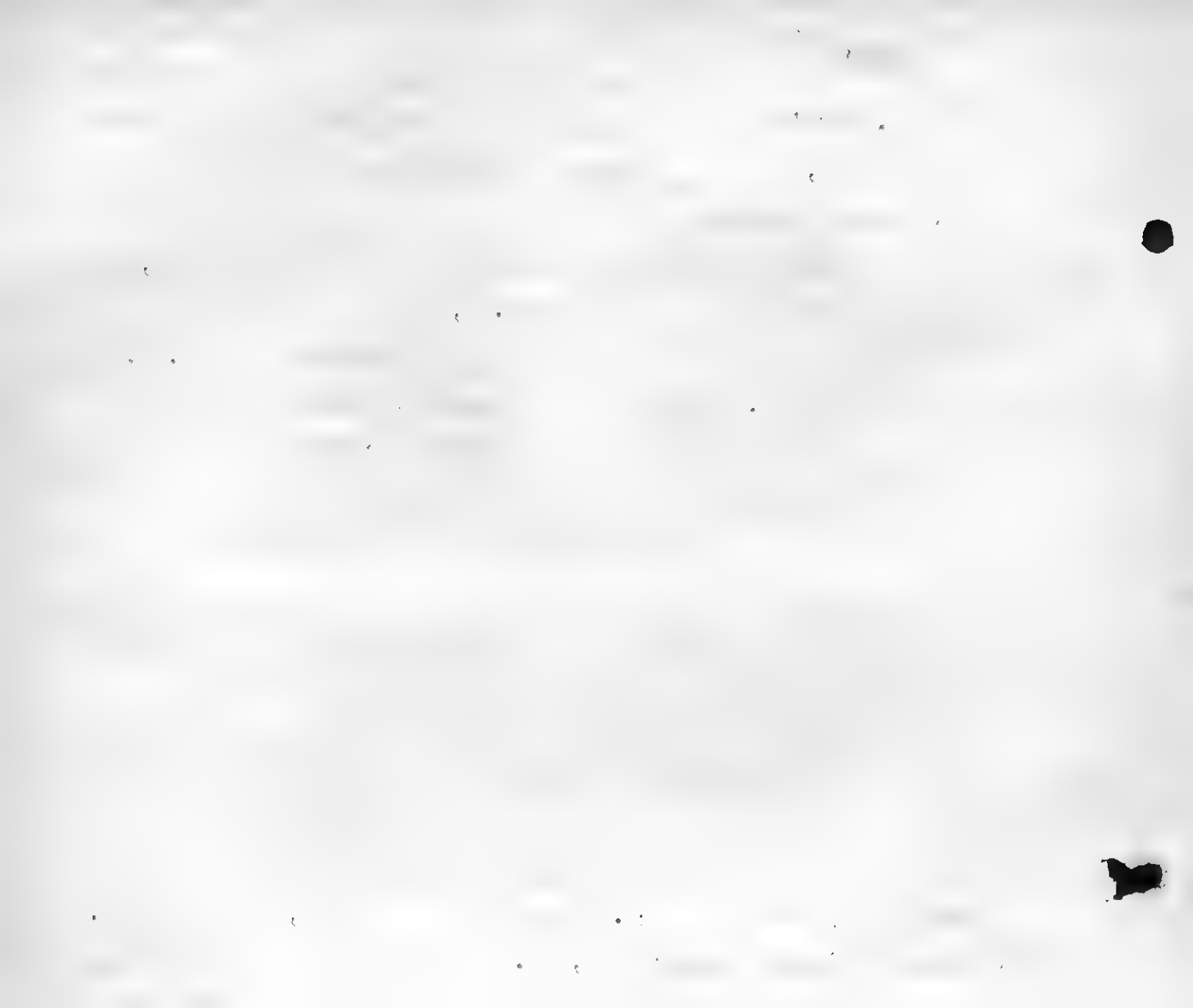
1. PLACE OF DEATH
 a. COUNTY **St. Mary's** **MARYLAND**
 b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Leonardtown,** c. LENGTH OF STAY IN b. **6 days**
 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **St. Mary's Hospital**
 3. NAME OF DECEASED (Type or print) First Middle Last **Bernard Holmes Raley**
 4. DATE OF DEATH Month Day Year **April 20, 1962**
 5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **Nov. 14, 1886** 9. AGE (In years last birthday) **75** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Farmer** 10b. KIND OF BUSINESS OR INDUSTRY **Farmer** 11. BIRTHPLACE (County & State, or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **U. S. A.**
 13. FATHER'S NAME **Walter R. Raley** 14. MOTHER'S MAIDEN NAME **Laura V. Holmes**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. **100-1-100000** 17. INFORMANT Address **Hospital Records**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Pulmonary Edema**
 420.0 DUE TO **Arteriosclerotic Heart Disease**
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) **Arteriosclerotic Heart Disease**
 (c) **Arteriosclerotic Heart Disease**
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).
Amputation of Gangrenous Foot. 16 April 62
 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
 20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **14 April 1962** 20f. (City or town) **16 April 1962** (County) **16 April 1962** (State) **16 April 1962**
 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION
 21. I certify that (I) (the hospital) attended the deceased from **14 April 1962** to **16 April 1962** that (I) (we) last saw the deceased alive on **14 April 1962** and that death occurred at **9 A.M.** from the causes and on the date stated above.
 22a. SIGNATURE **Ernest D. Rehm** M.D. 22b. DATE SIGNED **16 April 1962**
 22c. PHYSICIAN'S NAME (Type) **Ernest D. Rehm M.D.** 22d. ADDRESS **Lexington Park, Md.**
 23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **4/23/62** 23c. NAME OF CEMETERY OR CREMATORY **St. Michael's** 23d. LOCATION (City, town or county) **Ridge,** (State) **Md.**
 24. FUNERAL DIRECTOR'S SIGNATURE **W. Clarke Mattingley** ADDRESS **Leonardtown, Md.** 25a. REC'D BY REGISTRAR **APR 24 '62** 25b. REGISTRAR'S SIGNATURE **Arthur S. Kraus**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

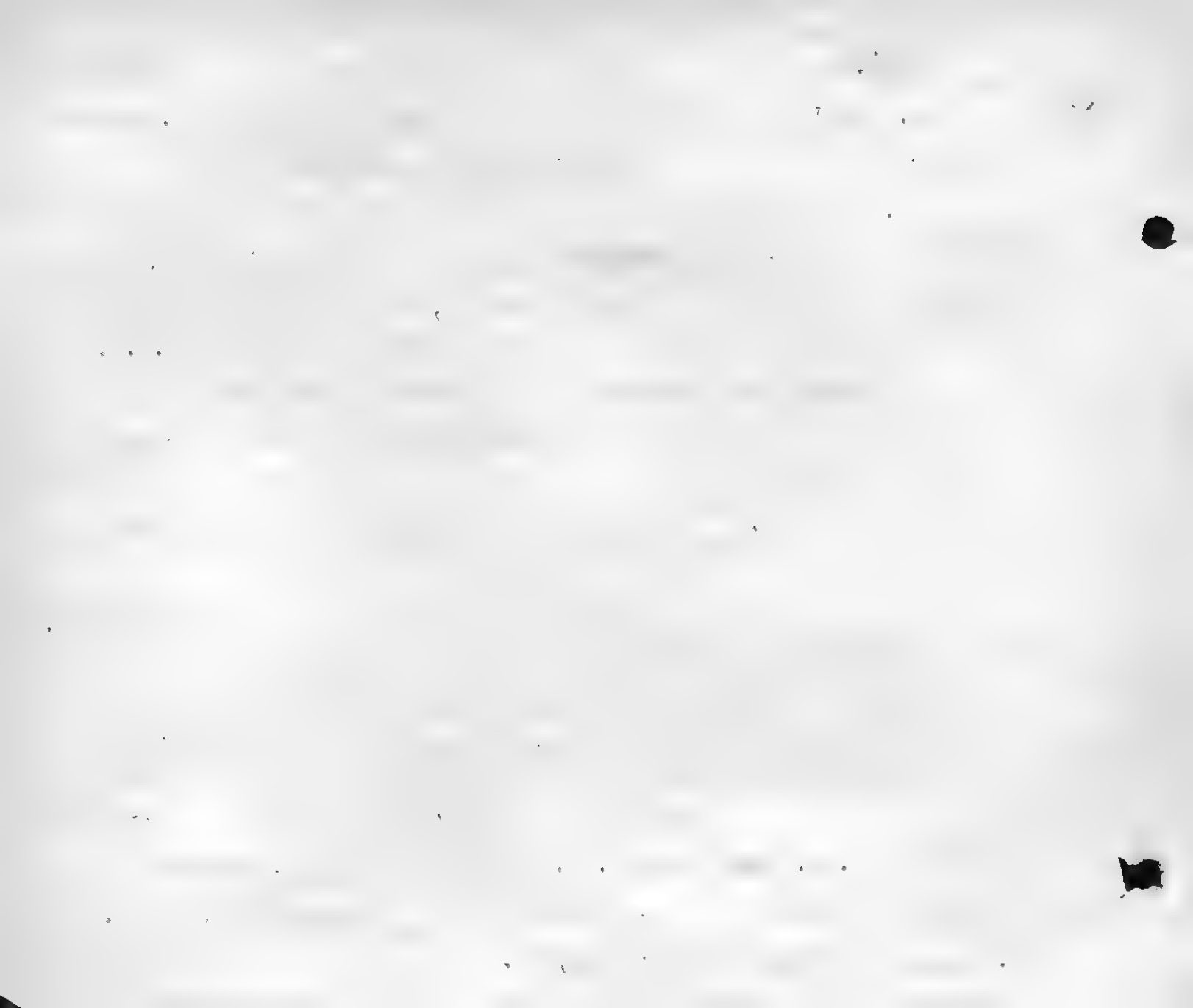
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05030

05027

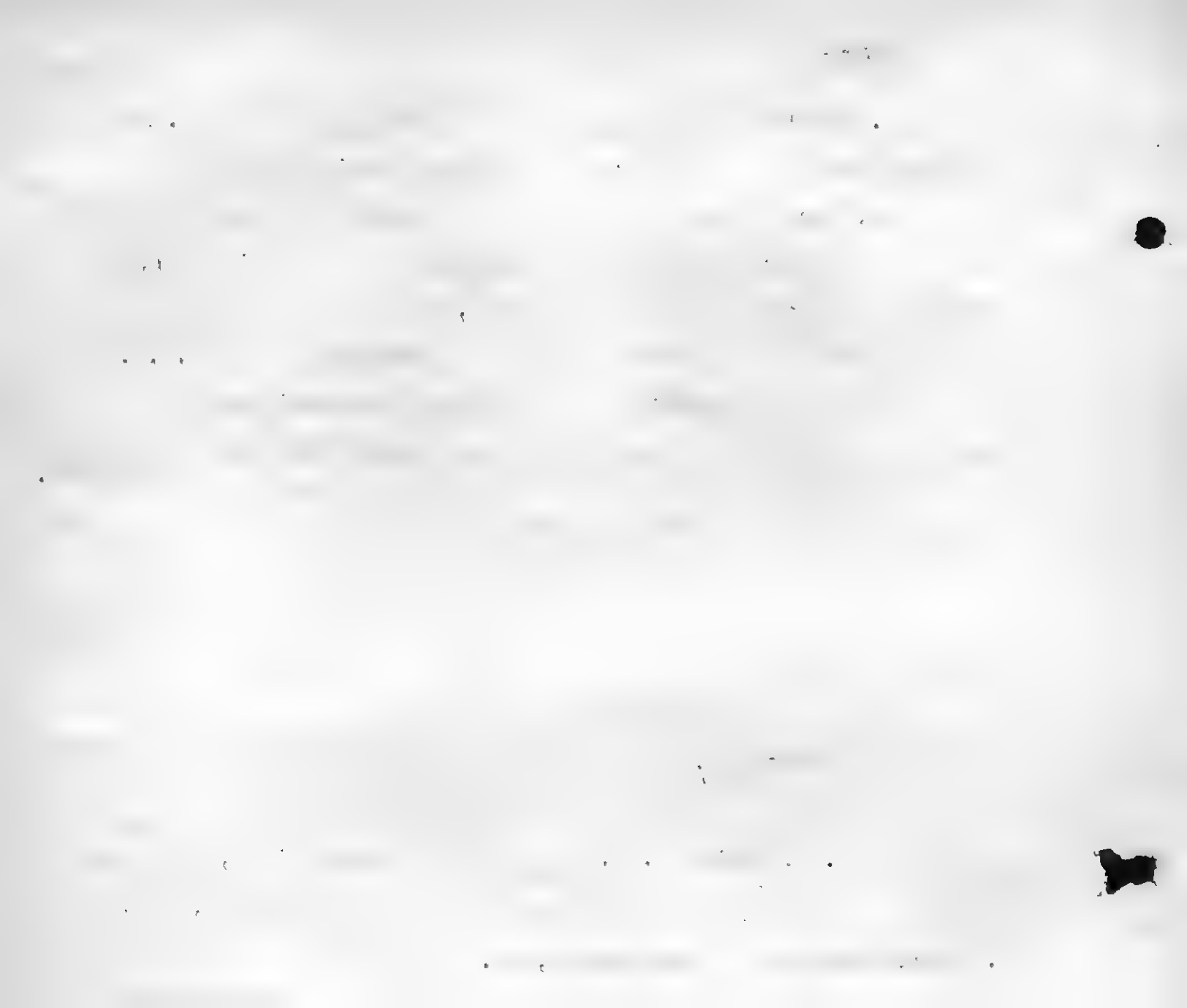
1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtwn c. LENGTH OF STAY IN b. 18 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Mary's Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Callaway d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret Bradburn Stone 4. DATE OF DEATH April 26, 1962		5. SEX Female 6. CO. OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH June 15, 1873 9. AGE (In years last birthday) 88 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M. n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Henry Bradburn 14. MOTHER'S MAIDEN NAME Margaret Ellen Lomax	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none 17. INFORMANT Mrs Rose Stone Callaway, Maryland Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carline arrest 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Cronary intrachloris (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Branch pneumonia 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from April 18, 1962 to April 24, 1962 that (I) (we) last saw the deceased alive on April 26, 1962 and that death occurred at 4 P.M. from the causes and on the date stated above.	
22a. SIGNATURE P. J. Bean 22c. PHYSICIAN'S NAME (Type) P. J. Bean M. D.		22b. DATE SIGNED 4/27/62 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Great Mills, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 4/30/62 23c. NAME OF CEMETERY OR CREMATORY Holy Face 23d. LOCATION (City, town or county) (State) Great Mills, Md.		24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley ADDRESS Leonardtwn, Md. 25a. REC'D BY REGISTRAR MAY 3 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hanes	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05031
05028

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown c. LENGTH OF STAY IN 1b 17 hrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Mary's Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Lexington Park d. STREET ADDRESS Rt 2 Box 61 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cora Rebecca Thompson First Middle Last		4. DATE OF DEATH April 12, 1962 Month Day Year	
5. SEX Female 6. COLOR OR RACE Colored 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH May 7, 1884 9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jefferson Johnson		14. MOTHER'S MAIDEN NAME Ellen Elizabeth Kane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? no (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. none 17. INFORMANT John L. Thompson Address Rt 2 Box 61 Lexington	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442X DUE TO HASCLVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) his (c) yes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Jan 4, 1962 to 4/12/62 that (I) yes last saw the deceased alive on 4/11/62 and that death occurred at 4:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE J. P. Jarboe 22c. PHYSICIAN'S NAME (Type) J. P. Jarboe M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Great Mills, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE HEREOF April 14, 1962	
23c. NAME OF CEMETERY OR CREMATORY Holy Face		23d. LOCATION (City, town or county) (State) Great Mills, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley ADDRESS Leonardtown, Md.		25a. REC'D BY REGISTRAR APR 13 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Farris	



TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
05032 05029											
1. PLACE OF DEATH a. COUNTY St. Marys b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Loveville c. LENGTH OF STAY IN b. 1 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rural				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Marys c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Loveville d. STREET ADDRESS Rural e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Leocodia S. Thompson				4. DATE OF DEATH April 20 1962				5. SEX male			
6. COLOR OR RACE negro				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 12/9/1961			
9. AGE (In years last birthday) 4				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Joseph E. Thompson				14. MOTHER'S MAIDEN NAME Laura Somerville			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) XXXXXXXXXXXXXXXXXXXXXXXXXXXX				16. SOCIAL SECURITY NO. XXXXXXXXXXXXXXXXXXXX				17. INFORMANT Laura Thompson - Loveville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 491X DUE TO (b) 491X DUE TO (c) 491X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) 491X											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 491X											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 491X											
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 491X 20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE Wm. D. Boyd M.D. DATE SIGNED 4/20/62											
EXAMINER'S NAME (Type) Wm. D. Boyd, MD Leonardtown, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 4/21/62 22c. NAME OF CEMETERY OR CREMATORY St. Joseph Cem. 22d. LOCATION (City, town, or country) (State) Morganza, Md.											
23. FUNERAL DIRECTOR P.B. Robinson - Leonardtown, Md. ADDRESS St. Joseph Cem.											
24a. REC'D BY REGISTRAR APR 24 '62 24b. REGISTRAR'S SIGNATURE Robinson, S. P.											



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05033

05030

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

St. Marys

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Abell

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Rural

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

St. Marys

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Abell

d. STREET ADDRESS

Rural

e. IS RESIDENCE ON A FARM?
YES ☒ NO ☐

3. NAME OF DECEASED (Type or print)

First

Middle

Last

MATTIE

MAGDALEN

VAN WORD

4. DATE OF DEATH

Month

Day

Year

April

8

19 62

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED

☒ NEVER MARRIED ☐

8. DATE OF BIRTH

May 14, 1892

9. AGE (In years last birthday)

69

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Nurse (retired) Civil Service

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Mathew Carrey

14. MOTHER'S MAIDEN NAME

Lucy Ashton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

no

16. SOCIAL SECURITY NO.

James W. VanWord - Abell, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

420

Conorary occlusion

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

5 min.

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY

Hour a.m.

Month, Day, Year

19

p.m.

20d. INJURY OCCURRED

While at work ☐

Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Wm. D. Boyd

M. D.

ASSISTANT MEDICAL EXAMINER

EXAMINER'S NAME (Type)

Wm. D. Boyd, MD

DEPUTY MEDICAL EXAMINER

Leonardtown, Md.

4/8/62

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/10/62

22c. NAME OF CEMETERY OR CREMATORY

Sacred Heart

22d. LOCATION (City, town, or country)

Bushwood, Md.

(State)

23. FUNERAL DIRECTOR

P.B. Robinson - Leonardtown, Md.

ADDRESS

24a. REC'D BY REGISTRAR

DATE APR 10 '62

24b. REGISTRAR'S SIGNATURE

Arthur S. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSTS: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND																			
05034																			
05031																			
Item 4 Film 0311 4/23/62 mh																			
1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park					c. LENGTH OF STAY IN TB 3 yrs					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 41 Lei Drive					d. STREET ADDRESS 41 Lei Drive					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last CARROLL BRUCE WEANT					4. DATE OF DEATH Month Day Year April 13, 1962														
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 3, 1877		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman (retired)					10b. KIND OF BUSINESS OR INDUSTRY Automobile					11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Samuel Weant					14. MOTHER'S MAIDEN NAME Margaret Delphy														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. ----					17. INFORMANT Address Margaret V. Weant - Lexington Park, Md									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4-20-1 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 hour										INTERVAL BETWEEN ONSET AND DEATH 1 hour									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Jan. 15, 1962 to April 13, 1962 that (I) (we) last saw the deceased alive on April 13, 1962 and that death occurred at 1:11 M, from the causes and on the date stated above.										22a. SIGNATURE Wm. H. Patrick					22b. DATE SIGNED 4/13/62				
22c. PHYSICIAN'S NAME (Type) Wm. H. Patrick, MD					22d. ADDRESS Lexington Park, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 4/16/62					23c. NAME OF CEMETERY OR CREMATORY Westminster Cem.					23d. LOCATION (City, town, or county) (State) Westminster, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Robinson					24b. ADDRESS Leonardtown, Md.					25a. REC'D BY REGISTRAR DATE APR 17 '62					25b. REGISTRAR'S SIGNATURE Arthur S. Evans				

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St. Louis

St. Louis

Anthony S. Kraus

YR A15 (4)
15M 7/61



02032

St. Mary's

in 1913

St. Mary's Hospital

after

White

Housewife

Henry T. White

Jan. 30, 1913

Portland

Portland, Oregon

The family and Mrs. Margaret

St. Mary's Hospital

St. Mary's Hospital
Portland, Oregon